UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Terrance Spence 13A5242

(In the space above enter the full name(s) of the plaintiff(s).)

-against-

New York City Department of Correction, Commissioner Joseph Ponte, First Deputy Commissioner Lewis Finkelman, E.S.U Captain McQuade, et. Al.

(In the space above enter the full name(s) of the defendant(s). If you cannot fit the names of all of the defendants in the space provided, please write "see attached" in the space above and attach an additional sheet of paper with the full list of names. The names listed in the above caption must be identical to those contained in Part I. Addresses should not be included here.)

AMENDED COMPLAINT
under the Civil Rights Act, 42 U.S.C. § 1983

Jury Trial: ☑ Yes ☐ No
(check one)

14 Civ. 8848 (JPO)

I. Parties in this complaint:

A. List your name, identification number, and the name and address of your current place of confinement. Do the same for any additional plaintiffs named. Attach additional sheets of paper as necessary.

Plaintiff's
Name Terrance Spence
ID# 13A5242
Current Institution Wyoming C.F.
Address P.O. Box 501
Attica, New York 14011-0501

B. List all defendants' names, positions, places of employment, and the address where each defendant may be served. Make sure that the defendant(s) listed below are identical to those contained in the above caption. Attach additional sheets of paper as necessary.

Defendant No. 1
Name New York City Dept. of Correction Shield #
Where Currently Employed
Address

Defendant No. 2 Name Joseph Ponte Shield #_____
Where Currently Employed Unknown
Address _____

Defendant No. 3 Name Lewis Finkelman Shield #_____
Where Currently Employed Unknown
Address _____

Who did what?

Defendant No. 4 Name Captain McQuade Shield # 1645
Where Currently Employed Unknown
Address _____

Defendant No. 5 Name _____ Shield #_____
Where Currently Employed _____
Address _____

II. Statement of Claim:

State as briefly as possible the facts of your case. Describe how each of the defendants named in the caption of this complaint is involved in this action, along with the dates and locations of all relevant events. You may wish to include further details such as the names of other persons involved in the events giving rise to your claims. Do not cite any cases or statutes. If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. Attach additional sheets of paper as necessary.

A. In what institution did the events giving rise to your claim(s) occur?
Robert N. Davoren center, 11-11 Hazen St. East Elmhurst, New York 11370

B. Where in the institution did the events giving rise to your claim(s) occur?
Housing Area 2 Central North Side

C. What date and approximate time did the events giving rise to your claim(s) occur?
January 10 2014 at about 5:30 AM

What happened to you?

D. Facts: On January 10 2014 at about 5:30 AM, an E.S.U team entered the housing area and started a search. When I was reached for my cell to be searched, I was searched then placed in plastic handcuffs that

cut off the circulation and feeling in my left-wrist due to them being extremely tight. After my cell was searched I was placed back in my cell after it was searched. I was kept in this condition even after making a complaint to these two unknown E.S.U Officers. I was left in this condition in my cell till about 8:30 AM. Then I was removed from my cell and made another verbal complaint to E.S.U Captain McQuade and another unknown E.S.U Captain and was ignored. Then I was dragged from the housing Area by my arms and placed on my knees. When I sat down I was kicked by an unknown E.S.U Officer. Then I was escorted to the RNDC's intake Area where I tried to let several others know of my need for medical attention. I was not given medical attention until 2:00 PM.

Was anyone else involved?

Who else saw what happened?

III. Injuries:

If you sustained injuries related to the events alleged above, describe them and state what medical treatment, if any, you required and received.

Temporary Paralosis, contusions, and abrasions to my left-wrist. I was treated with a cast, Pain Medication, and occupational therapy.

IV. Exhaustion of Administrative Remedies:

The Prison Litigation Reform Act ("PLRA"), 42 U.S.C. § 1997e(a), requires that "[n]o action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted." Administrative remedies are also known as grievance procedures.

A. Did your claim(s) arise while you were confined in a jail, prison, or other correctional facility?

Yes ✓ No ___

If YES, name the jail, prison, or other correctional facility where you were confined at the time of the events giving rise to your claim(s).

Robert N. Davoren Center, 11-11 Hazen Street East Elmhurst New York 11370.

B. Does the jail, prison or other correctional facility where your claim(s) arose have a grievance procedure?

Yes ✓ No ___ Do Not Know ___

C. Does the grievance procedure at the jail, prison or other correctional facility where your claim(s) arose cover some or all of your claim(s)?

Yes ___ No ___ Do Not Know ✓

If YES, which claim(s)?

D. Did you file a grievance in the jail, prison, or other correctional facility where your claim(s) arose?

Yes ___ No ✓

If NO, did you file a grievance about the events described in this complaint at any other jail, prison, or other correctional facility?

Yes ___ No ✓

E. If you did file a grievance, about the events described in this complaint, where did you file the grievance?

1. Which claim(s) in this complaint did you grieve?

2. What was the result, if any?

3. What steps, if any, did you take to appeal that decision? Describe all efforts to appeal to the highest level of the grievance process.

F. If you did not file a grievance:

1. If there are any reasons why you did not file a grievance, state them here:

Yes, was not given the chance because I was transfered back to the New York State Department of Corrections and Community Supervision.

2. If you did not file a grievance but informed any officials of your claim, state who you informed, when and how, and their response, if any:

I informed my housing area captain that day. An investigation was launched where I was interveiwed by Captain Crawford and a written report was made and pictures where taken of my injury.

G. Please set forth any additional information that is relevant to the exhaustion of your administrative remedies.

Note: You may attach as exhibits to this complaint any documents related to the exhaustion of your administrative remedies.

V. Relief:

State what you want the Court to do for you (including the amount of monetary compensation, if any, that you are seeking and the basis for such amount). I am seeking a monetary compensation in the amount of one million dollars (1,000,000) for injuries sustained while a ward of the state in the custody of the New York city Department of Corrections, further medical treatment, mental distress, and permanant injuries sustained from the incident.

VI. **Previous lawsuits:**

On these claims

A. Have you filed other lawsuits in state or federal court dealing with the same facts involved in this action?

Yes ____ No ✓

B. If your answer to A is YES, describe each lawsuit by answering questions 1 through 7 below. (If there is more than one lawsuit, describe the additional lawsuits on another sheet of paper, using the same format.)

1. Parties to the previous lawsuit:

Plaintiff _____
Defendants _____

2. Court (if federal court, name the district; if state court, name the county) _____

_____

_____ 3. Docket or Index number _____

_____ 4. Name of Judge assigned to your case _____

5. Approximate date of filing lawsuit _____

6. Is the case still pending? Yes ____ No ____

If NO, give the approximate date of disposition _____

7. What was the result of the case? (For example: Was the case dismissed? Was there judgment in your favor? Was the case appealed?) _____

_____

_____

On other claims

C. Have you filed other lawsuits in state or federal court otherwise relating to your imprisonment?

Yes ____ No ✓

D. If your answer to C is YES, describe each lawsuit by answering questions 1 through 7 below. (If there is more than one lawsuit, describe the additional lawsuits on another piece of paper, using the same format.)

1. Parties to the previous lawsuit:

Plaintiff _____
Defendants _____

2. Court (if federal court, name the district; if state court, name the county) _____

_____

_____ 3. Docket or Index number _____

_____ 4. Name of Judge assigned to your case _____

5. Approximate date of filing lawsuit _____

6. Is the case still pending? Yes ____ No ____

If NO, give the approximate date of disposition_____

7. What was the result of the case? (For example: Was the case dismissed? Was there judgment in your favor? Was the case appealed?) _____

_____

_____

I declare under penalty of perjury that the foregoing is true and correct.

Signed this ___ day of _____, 20__.

Signature of Plaintiff Tikhanne Spence

Inmate Number 13A5242

Institution Address Wyoming C.F.
PO Box 501
Attica, New York
14011-0501

Note: All plaintiffs named in the caption of the complaint must date and sign the complaint and provide their inmate numbers and addresses.

I declare under penalty of perjury that on this _____ day of _____, 20__, I am delivering this complaint to prison authorities to be mailed to the *Pro Se* Office of the United States District Court for the Southern District of New York.

Signature of Plaintiff: _____

Rec OTC 1/9/14 via Rikers

DOCCS FRM 3611A1 **State of New York - Department of Corrections and Community Supervision** PAGE 1 OF 2

Health Services Division

Inter-System Transfer / Pre-Screening Form – Medical Information

NAME SPENCE, TERRANCE 00000000
DOWNSTATE C.F.
DOWNSTATE, NY 00000

B&C: 24-DEC-85 B N M 5'7" 205 BRO BLK
NY M
SPENCE, YVETTE WF

Genera
accomp 8751400038 01789814L 09-JAN-14

DATE OF BIRTH: (mm/dd/yyyy) 12/24/85

DIN: (State use only) 13A5242

ections of this form when the health record does not
Chart Review ☐ Direct Encounter

SECTION I:

If "Yes" to any question #1 – 7, complete the form and **do not transfer patient** without contacting NYS Pre-Screening staff at Rikers Island (718-546-7241) **or** coordinating transfer information with the receiving facility medical staff to ensure medical supply/equipment access and follow up services are timely.

1. Pregnant — ☒ No ☐ Yes
2. Currently housed in an infirmary or isolation unit (if yes, or recurrently discharged, attach discharge summary): — ☒ No ☐ Yes
3. Physical disability (if yes, check below): — ☒ No ☐ Yes
   ☐ Wheelchair ☐ Brace/Splint ☐ Crutches
   ☐ Cane ☐ Prosthesis ☐ Walker
4. Requires durable medical equipment such as CPAP/Bi-PAP, insulin pump, infusion line, trachea suction. — ☒ No ☐ Yes
5. Unstable medical condition (i.e. recent seizure activity, significant hypo/hyperglycemic events) or transfer will interrupt ongoing speciality care such as dialysis, receiving chemotherapy/radiation therapy. — ☒ No ☐ Yes
6. Known exposure to or active illness with transmittable infectious disease (i.e. as active TB, MRSA, acute hepatitis A/B/C, measles, mumps, chicken pox, contact precautions, etc). — ☒ No ☐ Yes
7. Requires methadone/narcotic, injectable medications, any 1:1 drugs, special order medication or dressing material. OMH meds — ☐ No ☒ Yes

SECTION II:

Does the inmate have a problem with any of the following? Provide pertinent details.

Language Barrier	☒ No	☐ Yes	(Describe					)
Speech Impairment	☒ No	☐ Yes	Deaf	☐ No	☐ Yes	Mute	☐ No	☐ Yes
Legally Blind	☒ No	☐ Yes	Blind	☐ No	☐ Yes	One Eye ☐	Both Eyes ☐	
Asthma	☐ No	☒ Yes						
Diabetes	☐ No	☒ Yes	– on meds or cont tx stopped '10					
Seizures Disorder	☒ No	☐ Yes						
HTN/CVD	☒ No	☐ Yes						
HIV	☒ No	☐ Yes						
Dental	☐ No	☐ Yes						

Other significant problems: (L) wrist ORIF 2012, Adj. D/O, Seasonal Allergies

DOCCS FRM 3611A2 | State of New York - Department of Corrections and Community Supervision | PAGE 2 OF 2

Health Services Division

Inter-System Transfer / Pre-Screening Form – Medical Information

NAME: SPENCE, TERRANCE 00000000
DOWNSTATE C.F.
B & C #: DOWNSTATE, NY 00000
24-DEC-85 B N M 5'7" 205 BRO BLK
NY M
SPENCE, YVETTE WF

(First)

DATE OF BIRTH: (mm/dd/yyyy) 12/24/85

DIN: (State use only) 13A5242

Allergies: 8751400038 01789814L 09-JAN-14

Medications: ☐ No ☒ Yes (Attach Medication Profile or List below – include dosage and frequency)

- Albuterol MDI 2puff TID PRN

SECTION III: DIAGNOSTIC DATA (ATTACH ANY SIGNIFICANTLY ABNORMAL TEST)

Test	Date Done	Result	Test	Date Done	Result	Test	Date Done	Result
RPR/FTA	12-13	NR	Pap Smear			Anti-HAV		
HIV			GC/Chlamydia			HBsAg	12/13	(-)
CD4			Pregnancy			Anti-HBs	12/13	(+)
Viral Load			Mammogram			Anti-HBc	12/13	(-)
EKG			Other Cholesterol	12-3-13	179	Anti-HCV		
			Triglycerides	12-3-13	179			
			Glucose	12-3-13	88			

SECTION IV: IMMUNIZATION RECORD

Vaccine Name	Date Given	Vaccine Name	Date Given	Vaccine Name	Date Given
Hepatitis B #1	5/10	Twinrix #1		Meningococcal	
Hepatitis B #2	7/10	Twinrix #2		Pneumococcal	
Hepatitis B #3	12/10	Twinrix #3		Tetanus Toxoid	
Hepatitis A #1	5/10	MMR	3-17-10	Influenza	
Hepatitis A #2	7/10	Varicella		Diptheria/Tetanus	2-6-06
		Polio/PV			

PPD: Date Admin _____ Date Read _____ Result Qnant Neg (mm) Neg Pos _____ R.I. 3-3-13

CXR: Date 12-3-13 Result Norm (If abnormal, provide film copy with report)

FORM COMPLETED BY: (Print Name/Title) F. Ponzano RN2 DATE: (mm/dd/yyyy) 1/8/14

COMPLETED AT: (Facility Full Name) Downstate Corr Fac SIGNATURE PHONE # 845-831-6600

CHS 337 (7/05)
DOCCS 3611A2 (9/11)

COPIES: White (Receiving Institution); Canary (Intransit Institution); Pink (Sending Institution)

NYC Health

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

COLLATERAL INFORMATION NOTE

PATIENT'S LAST NAME	FIRST NAME	BOOK & CASE NUMBER
Spence	Terrance	875140036

NYSID Number	DATE	DOB	FACILITY	HOUSING LOCATION
01789814L	1/9/14	12/24/85	RNDC	RK

PROVIDER

DATE ATTEMPTED CONTACT WITH COMMUNITY PROVIDER:
☐ 1st Attempt ☐ 2nd Attempt

CONTACT SUCCESSFUL: ☐ YES ☐ NO

IF NO CONTACT, PLEASE EXPLAIN:

PROVIDER: Transfer in from Downstate

DIAGNOSES:

RECENT MEDICATIONS/DOSAGES:

DATES OF TREATMENT:

COMPLIANCE:

FUNCTIONAL STATUS:

FAMILY MEMBER

DATE ATTEMPTED CONTACT WITH A FAMILY MEMBER:
☐ 1st Attempt ☐ 2nd Attempt

CONTACT SUCCESSFUL: ☐ YES ☐ NO

IF NO CONTACT, PLEASE EXPLAIN:

NAME OF PROVIDER:

MEDICATION:

TREATMENT HISTORY:

DESCRIPTION OF DAILY LIFE:

SUGGESTIONS FOR CARE:

T. Spence 1/9/14
SIGNATURE DATE

Give my consent to Mental Health to discuss my Med/Psych/Substance Conditions with:

FAMILY / PERSONAL CONTACT:

ADDRESS: PHONE #: ( )

X LS-Supv
MENTAL HEALTH STAFF – PRINT AND SIGN

X Clinician
TITLE

NYC Health
Correctional Health Services

SPENCE, TERRANCE

NYSID: 01789814L BookCase: 8751400038
Facility Code: RNDC Housing Area: RR
28 Y old Male, DOB: 12/24/1985
DOWNSTATE C.F., 10, DOWNSTATE, NY-10460
Insurance: Self Pay
Appointment Facility: Robert N. Davoren Center (Adolescents)

01/09/2014 Appointment Provider: Daniel Ashitey, PA

Current Medications
None

Past Medical History
Asthma
DM Type 2
Traumatism, trauma
Amphetamine abuse
Cocaine dependence, episodic abuse
Polysubstance dependence

Allergies
fish: anaphylaxis: Allergy

Reason for Appointment
1. State Transfer In; Fast track
2. 28 y/o male state intake with h/o asthma; uses albuterol mdi. Also alludes to h/o DM, but claims "I don't take any medicine; I stopped taking medicine in 2010". Patient also claims"I take psych meds;" On Benadryl and zoloft
3. Currently denies any s/h ideations; no a/v hallucinations. Will refer to mental health for evaluation for medication
4. As per ecw review A1C on 3/30/2013=5.0; On 7/15/2013= 5.1. Finger stick on presentation today =100mg/dl
5. Patient IS NOT DIABETIC, and will not clasify as such

History of Present Illness
TEMPLATES:

State Transfer In/FAST TRACK
Patient Chart Reviews:
Patient Labs Review (Completed by: NURSING)
Intake History and Physical Documented: *Yes*
RPR Date: *12/03/2013/*
RPR Results: *Negative/*
PPD/QFT Reading Date: *12/03/2013/*
PPD/QFT Results: *Negative/*
CXR Date: *12/03/2013/*
CXR Results: *Normal/*
Priority Review Required: *Yes*
Reason Priority Chart Required: *Other(Please describe) Fast Track*

Patient Status Review (Completed by: NURSING)
Chronic Care Issues: *Yes/DM, Asthma*
Requires Medication: *Yes/Albuterol*
Mental Health Follow-Up: *Routine/*
Allergies updated (In "Allergies"): *Yes/Fish*
Past Vaccinations Documented (In "Immunizations"): *Yes/*
Requires Therapeutic Diet: *Yes/*

VISIT COMPLEXITY SCALE:
INTAKE ACUITY
Intake Acuity Scale *3: 2 or 3 chronic conditions*

Vital Signs

Ht		
5 ft 7 in	01/09/2014 08:20:28 PM	Dionne James
Wt		
203	01/09/2014 08:20:28 PM	Dionne James
BMI		
31.79	01/09/2014 08:20:28 PM	Dionne James
BP		
107/65	01/09/2014 08:20:28 PM	Dionne James
Pulse		
99	01/09/2014 08:20:28 PM	Dionne James
RR		
16	01/09/2014 08:20:28 PM	Dionne James
Temp		
98.2	01/09/2014 08:20:28 PM	Dionne James
Peak Flow		
520	01/09/2014 10:40:39 PM	Uchenna Konkwo
SaO2		
99	01/09/2014 10:40:39 PM	Uchenna Konkwo
Glucose		
100	01/09/2014 09:45:12 PM	Shachana Harris

Physical Examination

Not indicated at this current moment; patient has no medical complaints; fast track.

Assessments

1. Screening examination for pulmonary tuberculosis - V74.1 (Primary)
2. ASTHMA NOS - 493.90, ; well controlled
3. Screening examination for unspecified infectious disease - V75.9
4. Mood disorder NOS - 296.90
5. HX-SEAFOOD ALLERGY - V15.04
6. OBESITY NOS - 278.00, ; BMI > 30

Treatment

1. Screening examination for pulmonary tuberculosis

LAB: QUANTIFERON-TB IN-TUBE NY

2. ASTHMA NOS
Start Albuterol Sulfate HFA Aerosol Solution, 108 (90 base) MCG/ACT, 2 puffs, po/inh, qid/prn, 90 days, Pharmacy, Refills 0

3. Screening examination for unspecified infectious disease
LAB: Rapid HIV Test

4. Mood disorder NOS
Referral To:Mental Health RNDC Mental health
Reason:h/o mood d/o; on psych meds

5. OBESITY NOS
Referral To:Dietary (REF) RNDC Dietary
Reason:obesity

Immunization
Pneumococcal - Refused
Hepatitis B (20 and more) - Refused : 1.0 mL
Influenza - Refused

Preventive Medicine
Counseling:
Smoking .
Seatbelts .
Guns in home .
Alcohol and drugs .

Diet .
Exercise .
Injury prevention .
Sexual practices .
Domestic violence .

Procedure Codes
90732 Pneumococcal - Refused
90746 Hepatitis B (20 and more) - Refused
90746 HEP B VACCINE, ADULT, IM
90658 Influenza - Refused

Disposition: Mental Health

Appointment Provider: Daniel Ashitey, PA

Electronically signed by Daniel Ashitey PA on 01/09/2014 at 11:59 PM EST

Sign off status: Completed

Robert N. Davoren Center (Adolescents)
11-11 Hazen Street
East Elmhurst, NY 11370
Tel: 718-546-6950
Fax:

Patient: SPENCE, TERRANCE DOB: 12/24/1985 Progress Note: Daniel Ashitey, PA 01/09/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

CORRECTION DEPARTMENT
CITY OF NEW YORK

INJURY TO INMATE REPORT

Page 1 of 2 Pages | Form: #167R-A Rev.: 01/31/08 Ref.: Dir. #4516R-A

INSTRUCTIONS: Original Report to Security, One copy to Clinic Lock Box, One Copy to Inmate Medical File.

Command:	Date:	COD/UOF #:	Injury #:
RNDC	1/10/14		1918/14

TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT CLEARLY).

Inmate Name (Last Name, First Name): Spence Terrence.

Location:	Work:	NYSID #:	Book & Case/Sent #:
2CN		01789814L	375140038

Details: On Friday January 10, 2014 at approx. 1415 hrs Inmate Spence Terrence #375140038 claiming he injured his left wrist.

Supervisor Notified (Print Last Name, First Name, Rank, Shield #):	Date:	Time:
Capt Krupp	1/10/14	approx 1415 Hrs.

Employee: ☐ (Did) ☒ (Did Not) Witness This Injury. | Employee Signature: | Rank/Title: C.O | Shield/ID#: 12454

TO BE COMPLETED BY MEDICAL STAFF ONLY (PLEASE PRINT CLEARLY)

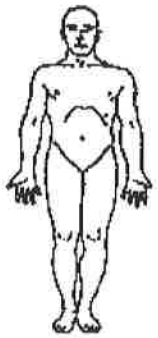
Date of Injury:	Reported for Medical Attention:	Inmate Refused Medical Attention:	Visible Injuries:
1/10/14	Date 1/10/14; 1800 Hrs.	☐ Yes ☒ No	☒ Yes ☐ No

Nature of Injury and Cause:

Cause of injury (as stated above): Patient claims he was involved in use of force with DOC.

Nature of injury: Left Wrist Pain with mild swelling

Medical Staff Must Note Location of Injury:



Treatment:
1. Education / Assurance
2. Ice pack
3. Pain medication
4. X-Ray to the grieved

Treated By/Examined By (Print and Sign Full Name): DANIEL ABITEBOUL | Title: PMD

Referrals to Other Medical Services (If Yes, Document Medical Findings): ☒ Yes ☐ No

X-Ray / Ortho care

Treated By/Examined By (Print and Sign Full Name): DANIEL ABITEBOUL | Title: PMD

Please Check Disposition:
☐ Refuse to Housing Area ☐ Work Release ___ Days ☐ Light Duty ___ Days ☐ Return to Work Assignment ☐ Re-Exam ___ Days ☐ Refer to Clinic ☐ Return to School

☐ Transfer to Hospital (indicate Name of Hospital): ☐ Life Threatening Emergency ☐ Routine

☐ Other (Please Specify):

Treated By (Print Full Name and Title, Sign Name): DANIEL ABITEBOUL PMD | Date: 1/10/14 | Time: 1745 Hrs

I certify that the cause of injury as stated herein is to my knowledge true and medical attention was provided:

Inmate Signature:	DIN/Sentence #:	Date:
	14A0038	1/10/14
Witnessed By (Signature):	Rank/Title: C/O	Shield/I.D. #: 10M	Date: 1/10/14

NYC Health
Correctional Health Services

SPENCE, TERRANCE

NYSID: 01789814L BookCase: 8751400038
Facility Code: RNDC Housing Area: 2CN
28 Y old Male, DOB: 12/24/1985
DOWNSTATE C.F., 10, DOWNSTATE, NY-10460

Insurance: Self Pay
Appointment Facility: Robert N. Davoren Center (Adolescents)

01/10/2014

Appointment Provider: Daniel Ashitey, PA

Current Medications

Albuterol Sulfate HFA 108 (90 base) MCG/ACT Aerosol Solution 2 puffs qid / prn, stop date 04/09/2014

Past Medical History

Asthma
DM Type 2
Traumatism, trauma
Amphetamine abuse
Cocaine dependence, episodic abuse
Polysubstance dependence

Allergies

fish: anaphylaxis: Allergy

Reason for Appointment

1. Injury report # 1918

History of Present Illness

TEMPLATES:

Rikers Injury Report

Injury Report:

General

Injury Report #: *1918 /*
Event Location: *Housing Area /*
Intentionality: *Unintentional /*
Cause: *DOC use of force/ alleged attack by staff /*
Verified Injury: *Injury by history only /*
Did the patient have a blow to the head? *No /*
Did the patient ever lose consciousness? *No /*
Was the patient ever dazed and confused after injury? *No /*

VISIT COMPLEXITY SCALE:

NON-INTAKE ACUITY

Non-Intake Acuity Scale *2: Complicated sick call (problem requiring diagnostic evaluation, documented history, physical exam, specified follow up) OR One chronic condition addressed with components specified in (3)*

Vital Signs

BP		
110/84	01/10/2014 05:38:55 PM	Daniel Ashitey
Pulse		
75	01/10/2014 05:38:55 PM	Daniel Ashitey
RR		
16	01/10/2014 05:38:55 PM	Daniel Ashitey
Temp		
98.8	01/10/2014 05:38:55 PM	Daniel Ashitey
Pain scale		

8	01/10/2014 06:03:20 PM	Daniel Ashitey

Examination

General Examination:

GENERAL APPEARANCE: well-developed, no acute distress.
HEENT: **HEAD:-**, normocephalic, atraumatic, no scalp lesions, **EYES:-**, PERRLA, EOMI.
ORAL CAVITY: normal.
NECK: supple, non-tender.
HEART: normal.
CHEST: normal, CHEST WALL:-, non-tender.
LUNGS: clear to auscultation bilaterally.
ABDOMEN: soft, NT/ND, BS present.
SKIN: mild erythema left wrist ; no break in skin.
EXTREMITIES: radial side of left wrist is + for tenderness; (past hx of left wrist fx with ORIF 2012); ROM < due to tenderness; mild skin erythema; no gross swelling noted. skin is intact; no open wound.
PERIPHERAL PULSES: normal.
BACK: unremarkable.
MUSCULOSKELETAL: shoulders full range of motion.
NEUROLOGIC EXAM: <ROM left wrist.

Assessments

1. Contusion - 861.01, ; left wrist; past h/o Lt wrist fx 2012; r/o re-injury (new fx); stable

Treatment

1. Contusion

Start Tylenol Tablet, 325 MG, 2 tabs, Orally, bid/prn, 4 days; stat, Pharmacy, Refills 0
Diagnostic Imaging:Wrist Left Ap, Oblique, Lateral (XRAY)
education / assurance; ice pack; tylenol for pain ; x-ray to /urgicare; accepted by Dr Meletiche; RN and DOC informed.

Disposition: X-Ray/Urgicare

Appointment Provider: Daniel Ashitey, PA

Electronically signed by Daniel Ashitey PA on 01/10/2014 at

10:54 PM EST

Sign off status: Completed

Robert N. Davoren Center (Adolescents)
11-11 Hazen Street
East Elmhurst, NY 11370
Tel: 718-546-6950
Fax:

Patient: SPENCE, TERRANCE DOB: 12/24/1985 Progress Note: Daniel Ashitey, PA 01/10/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

NYC Health
Correctional Health Services

Insurance: Self Pay

SPENCE, TERRANCE

NYSID: 01789814L BookCase: 8751400038
Facility Code: RNDC Housing Area: 2CN
28 Y old Male, DOB: 12/24/1985
DOWNSTATE C.F., 10, DOWNSTATE, NY-10460

Appointment Facility: West Facility

01/10/2014

Appointment Provider: CARLOS MELETICHE, MD

Current Medications

Albuterol Sulfate HFA 108 (90 base) MCG/ACT Aerosol Solution 2 puffs qid / prn, stop date 04/09/2014
Zoloft 100 mg Tablet 150mg At Bedtime, stop date 01/17/2014
Benadryl 100 mg Capsule 2 tabs At Bedtime, stop date 01/17/2014

Past Medical History

Asthma
DM Type 2
Traumatism, trauma
Amphetamine abuse
Cocaine dependence, episodic abuse
Polysubstance dependence

Allergies

fish: anaphylaxis: Allergy

Reason for Appointment

1. Involved in use of force with DOC and C/0 of severe pain to left wrist. Unable to move it and has diminished sensation around the thumb. AML RN

History of Present Illness

Notes:

UTD with tetanus toxoid. AML RN

Above history confirmed. Inmate also endorses prior left distal radius fracture requiring hardware insertion three years ago. CM MD.

Vital Signs

BP		
115/78	01/10/2014 10:34:39 PM	AnneMarie Legrand
Pulse		
76	01/10/2014 10:34:39 PM	AnneMarie Legrand
RR		
16	01/10/2014 10:34:39 PM	AnneMarie Legrand
Temp		
98.0	01/10/2014 10:34:39 PM	AnneMarie Legrand

Examination

General Examination:

GENERAL APPEARANCE: well-hydrated, no acute distress.

HEENT: **HEAD:-**, normocephalic, atraumatic, **EYES:-**, EOMI, **ORAL CAVITY:-**, moist mucosa.

NECK: GENERAL:-, supple.

EXTREMITIES: Left wrist with painful ROM; TTP along the extensor pollicis longus; Thumb sensation and motor function intact.

Balance of exam is non-contributory.

Assessments

Left Wrist Sprain
Prelim rads left wrist: Distal radius hardware in place; No new fracture

or dislocation CM MD.

Procedures

Splint:

Type of splint Ortho-glass.
Applied by Urgi MD.
Examined post-splinting neurovascular signs intact, alignment good.

Follow Up

Clinic as needed (Reason: Left Wrist Injury)

Disposition: General Population
Notes: Splint/ sling applied Analgesia as needed WF Ortho Followup

Appointment Provider: CARLOS MELETICHE, MD

Electronically signed by Carlos Meletiche MD on 01/10/2014 at 11:12 PM EST

Sign off status: Completed

West Facility
16-06 Hazen Street
East Elmhurst, NY 11370
Tel: 718-546-4150
Fax:

NYC Health
Correctional Health Services

SPENCE, TERRANCE

NYSID: 01789814L BookCase: 8751400038
Facility Code: RNDC Housing Area: 2CN
28 Y old Male, DOB: 12/24/1985
DOWNSTATE C.F., 10, DOWNSTATE, NY-10460
Insurance: Self Pay
Appointment Facility: Robert N. Davoren Center (Adolescents)

01/11/2014

Appointment Provider: Tasbirul Alam, MD

Current Medications

Albuterol Sulfate HFA 108 (90 base) MCG/ACT Aerosol Solution 2 puffs qid / prn, stop date 04/09/2014
Zoloft 100 mg Tablet 150mg At Bedtime, stop date 01/17/2014
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Past Medical History

Asthma
DM Type 2
Traumatism, trauma
Amphetamine abuse
Cocaine dependence, episodic abuse
Polysubstance dependence

Allergies

fish: anaphylaxis: Allergy

Reason for Appointment

1. Urgicare return

History of Present Illness

Notes::

Patient with s/p left wrist sprain, covered with wrist splint came from Urgicare; as per urgicare patient has a f/up to see orthopedic specialist; he reports pain is dull in nature and not feeling pain at this moment;.

VISIT COMPLEXITY SCALE:

c/o NON-INTAKE ACUITY

Non-Intake Acuity Scale *2: Complicated sick call (problem requiring diagnostic evaluation, documented history, physical exam, specified follow up) OR One chronic condition addressed with components specified in (3)*

Vital Signs

BP		
Sitting: 110/70	01/11/2014 12:52:06 AM	Tasbirul Alam
Pulse		
70	01/11/2014 12:52:06 AM	Tasbirul Alam
RR		
14	01/11/2014 12:52:06 AM	Tasbirul Alam
Temp		
97.6	01/11/2014 12:52.06 AM	Tasbirul Alam

Examination

General Examination:

GENERAL APPEARANCE: well-appearing, no acute distress

HEENT: **HEAD:-**, normocephalic, atraumatic, **EYES:-**, PERRLA, EOMI, **FUNDI:-**, disc not visualized, **EARS:-**, normal, **NOSE:-**, normal pink mucosa, **THROAT:-**, clear, **ORAL CAVITY:-**, moist mucosa,

NECK: supple.

HEART: normal.
CHEST: normal.
LUNGS: clear to auscultation bilaterally.
ABDOMEN: soft, NT/ ND, BS present.
SKIN: normal.
EXTREMITIES: left wrist is covered with a splint and hanged from collar sling.
PERIPHERAL PULSES: normal (2+) bilaterally
BACK: unremarkable.
MUSCULOSKELETAL: normal range of motion all joints except left wrist.
NEUROLOGIC EXAM: alert and oriented x 3, normal cranial nerves II-XII sensory & motor WNL, DTR 2 plus, CN's II-XII grossly intact, normal sensation, gait normal, babinski - negative.
MENTAL STATUS: alert, awake, oriented x 3, psychomotor activity normal, normal speech, good eye contact, euthymic mood.

Assessments
1. JOINT PAIN-HAND - 719.44 (Primary), left wrist injury

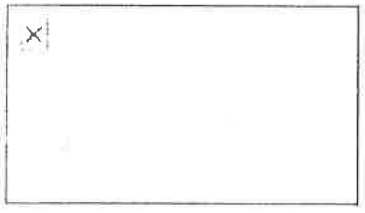
Treatment
1. JOINT PAIN-HAND
Start Ibuprofen Tablet, 400 MG, 1 tab, Orally, Three Times a Day, 5 days, Pharmacy, Refills 0
stable; on a splint; patient educated.

Follow Up
prn

Disposition: General Population

Addendum:
01/ 11/ 2014 04:17 AM Morgan, Audrey > Stat medications Zoloft tab. 150 mg po and Benadryl caps 200 mg. po given at 1:30 AM and well tolerated

Appointment Provider: Tasbirul Alam, MD



Electronically signed by Tasbirul Alam on 01/11/2014 at 01:06 AM EST

Sign off status: Completed

Robert N. Davoren Center (Adolescents)
11-11 Hazen Street
East Elmhurst, NY 11370
Tel: 718-546-6950
Fax:

3105A317 (11)

STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

AMBULATORY HEALTH RECORD PROGRESS NOTE

Name	DIN	Date of Birth	Facility Name

Subjective: Court Return x 1 1/2 mo

DCF

Last Name Spence Terrance

DIN 13A5242 Location

Date 2/19/14 Time 1225p

Objective: 1/10/14 - Clo fx to L wrist hard cast & ace bandage

Provider Orders: Albuterol hfa pen

Assessment: NSP

-claims Sx ORIF. flu s/c in AM

Plan: OMH meds

Signature/Provider # [signature] RN Transcribing Order/Provider #/Date/Time [signature]

Subjective:

Last Name

DIN Location

Date Time

Objective:

Provider Orders:

Assessment:

Plan:

Signature/Provider # RN Transcribing Order/Provider #/Date/Time

Subjective:

Last Name

DIN Location

Date Time

Objective:

Provider Orders:

Assessment:

Plan:

Signature/Provider # RN Transcribing Order/Provider #/Date/Time

Continue entry into next box if necessary.

DOWNSTATE CORRECTIONAL FACILITY

TO: Security

FROM: Medical

RE: Name: Spence Terrance

Number: 13A5242

Cell: _____

DATE:

_____ Feed on Gallery _____ days

_____ Rec on Gallery _____ days

_____ No Recreation _____ days

_____ No Shave _____ days

_____ Cane Pass _____ days

_____ Crutch Pass _____ days

_____ Sneaker Pass _____ days

✓ cast and ace bandage x 5 days

Restricted to cell for _____ days

Should report to sick call on _____

Date: 2/19/14

_____

Nurse Signature

_____

Physician of PA Signature

All restrictions will continue through the expiration date.

DN020

Spence 15A5042
g Correctional Facility
x 501
ca N.Y. 14011-0501

WYOMING
CORRECTIONAL
FACILITY

USM P3
SDNY

Pro-Sé Intake unit
Clerk
United States District
Southern District of New Y
The Daniel Patrick Moyniha
Courthouse
500 Pearl Street
New York, N.Y. 10007-

RECEIVED
SDNY PRO SE OFFICE
2015 DEC 16 AM 10: 17

"urgent"